Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement of $5,076.06 for date of service, 10/25/02.

   b. The request was received on 06/19/02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92
   c. Itemized hospital bill
   d. EOB/TWCC 62 forms/Medical Audit summary
   e. Redacted example EOBs from other carriers
   f. Medical Records
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution dated
   b. UB-92
   c. Itemized hospital bill
   d. Medical Audit summary/EOB/TWCC 62 form
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 08/02/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/06/02. The respondent did not respond to the additional documentation. It's initial response is reflected in Exhibit II.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: No position statement found.

2. Respondent: Statement found on the Carrier's TWCC 60 – undated

   "Your req. for reconsideration has been received & reviewed. (Carrier's) payment was made in accordance with section 413.011 of the Tx. WC Act. No additional payment is warranted."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/25/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,976.06.00 for services rendered on the above date in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $900.00 for services rendered on the above date in dispute.

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $5,076.06.

6. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, Radiology services, anesthesia equipment, EKG/ECG monitor, and Recovery Room services.

7. The carrier denied the billed charges by denial code "G,226 INCLUDED IN GLOBAL CHARGE." and "F,722 O/P TREATMENTS OF 30-60 MINUTES IN THE O.R. ARE PAID NOT TO EXCEED INPATIENT SETTING AND PER SECTION 413.011(B) OF THE TEXAS WC ACT". The Carrier has denied this ASC charge as global, but as this is an Ambulatory Surgical Facility, all charges would be global to the fee requested. Therefore, since there is no MAR, this will be addressed as fair and reasonable.

## V. RATIONALE

Medical Review Division's rationale:

Per the Texas Worker's Compensation Act and Rules §413.011(d), "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The carrier asserts that they have paid a fair and reasonable reimbursement but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable.

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The provider should submit evidence to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted redacted EOB(s) from other carriers. However, these example EOBs do not list an ICD-9 code to demonstrate the service provided was for a similar treatment of a similar worker's compensation injury.

The provider's documentation does not justify or demonstrate that the fees requested are fair and reasonable. Therefore, no further reimbursement is recommended.

The above Findings and Decision are hereby issued this 4th day of February 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt